

# CAMP ROCKIN' U HEALTH FORM

The information on this form is not part of the camper or staff acceptance process, but is gathered solely to assist us in identifying appropriate care. Pages 1 to 3 are to be completed and signed by the camper's parent or the adult staff member. Page 4 is to be completed and signed by your licensed physician. Please print or type all information.

CAMP ROCKIN' U

P.O. BOX 502 DOBBINS, CA 95935

PLEASE ATTACH  
A RECENT WALLET-SIZED  
PHOTOGRAPH.

Print your first & last name  
on the back of the photograph.

**REMINDERS:**

Attach a copy (both sides) of your  
medical/prescription insurance card  
to the inside of this form.  
Keep a copy of this form & let us know  
if any condition changes between  
examination time and arrival at camp.

ENTRY #:

Name: \_\_\_\_\_  
Last Name First Name Middle Name

Birth date: \_\_\_\_\_ Age at camp: \_\_\_\_\_ Gender:  Male,  Female

Home address: \_\_\_\_\_  
Street Address City State Zip

Participant's telephone #: \_\_\_\_\_ Social security #: \_\_\_\_\_

CABIN:

**NAME OF CUSTODIAL PARENT** (1<sup>st</sup> person to contact): \_\_\_\_\_

Relationship:  Mother,  Father,  Other (please describe): \_\_\_\_\_

Home phone #: \_\_\_\_\_ Work phone #: \_\_\_\_\_  
(if different from participant)

Cell phone #: \_\_\_\_\_  Home or  Work fax machine #: \_\_\_\_\_

Home address: \_\_\_\_\_  
(if different from participant) Street Address City State Zip

Business address: \_\_\_\_\_  
Street Address City State Zip

SESSION:

**NAME OF SECOND PARENT OR GUARDIAN** (2<sup>nd</sup> person to contact): \_\_\_\_\_

Relationship:  Mother,  Father,  Other (please describe): \_\_\_\_\_

Home phone #: \_\_\_\_\_ Work phone #: \_\_\_\_\_  
(if different from participant)

Cell phone #: \_\_\_\_\_  Home or  Work fax machine #: \_\_\_\_\_

Home address: \_\_\_\_\_  
(if different from participant) Street Address City State Zip

Business address: \_\_\_\_\_  
Street Address City State Zip

**NAME OF EMERGENCY CONTACT** (3<sup>rd</sup> person to contact if parents are unreachable): \_\_\_\_\_

Relationship: \_\_\_\_\_ Home phone #: \_\_\_\_\_ Work phone #: \_\_\_\_\_

Home address: \_\_\_\_\_  
Street Address City State Zip

**MEDICAL INSURANCE COVERAGE INFORMATION:** In addition to completing the section below, you are required to attach a copy (both sides) of your medical/prescription insurance card.

Name of insurance company: \_\_\_\_\_ Primary card holder: \_\_\_\_\_

Address of insurance company: \_\_\_\_\_  
Street Address City State Zip

ID membership #: \_\_\_\_\_ Group # of your medical plan: \_\_\_\_\_

NAME:

## PERMISSION TO TREAT - SIGNATURE REQUIRED

I authorize the camp medical staff to administer over-the-counter medications and medicines prescribed for my child, including medications that my child brings to camp, those listed as medications my child is currently taking, and medications needed in the care and treatment of my child. I hereby give permission to the medical personnel selected by the camp director to administer prescribed medications; to order x-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide necessary related transportation for me/or my child. In the event that I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization, for the person named above. This completed form may be copied for trips out of camp.

**SIGNATURE OF PARENT, GUARDIAN, OR STAFF MEMBER:** \_\_\_\_\_

Print your name: \_\_\_\_\_ Date: \_\_\_\_\_

**HEALTH HISTORY:**

The following information must be completed by the parent/guardian, or adult camper or adult staff member. The intent of this information is to provide the camp health care personnel the background to provide appropriate care. Keep a copy of the completed form for your records. Any changes to this form (between time of completion and arrival at camp) should be provided to the camp's health care personnel upon the participant's arrival in camp. Provide complete information so that the camp can be aware of your needs.

**ALLERGIES:**

MEDICATION ALLERGIES (list below):

DESCRIBE HOW THE REACTION IS MANAGED:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

FOOD ALLERGIES (list below):

DESCRIBE HOW THE REACTION IS MANAGED:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

OTHER ALLERGIES (list below):

Include insect stings, hay fever, animal dander, etc.

DESCRIBE HOW THE REACTION IS MANAGED:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**MEDICATIONS BEING TAKEN:**

Please list ALL medications taken routinely (including prescription drugs, non-prescription drugs, and over-the-counter meds). Be sure to bring enough medications for your entire stay at camp. Medications are to be kept in the original package/bottle that identifies the prescribing physician (if it's a prescription drug), name of medication, when the medicine is to be administered, frequency, proper dosage, and any other special instructions (ie. keep refrigerated).

- This person takes no medications on a routine basis.
- This person takes medications on a routine basis and will continue to do so during his/her stay at camp. Please identify meds below.
- This person no longer takes medications, but in the past had taken medication for hyperactivity, ADD, ADHD and/or any other complex medical condition (physical or mental)? Please identify meds below.

Name of Medication #1: \_\_\_\_\_ Dosage \_\_\_\_\_ Specific times taken each day \_\_\_\_\_

Reason for taking \_\_\_\_\_

Name of Medication #2: \_\_\_\_\_ Dosage \_\_\_\_\_ Specific times taken each day \_\_\_\_\_

Reason for taking \_\_\_\_\_

Name of Medication #3: \_\_\_\_\_ Dosage \_\_\_\_\_ Specific times taken each day \_\_\_\_\_

Reason for taking \_\_\_\_\_

Attach additional pages for additional medications.

**RESTRICTIONS:** The following restrictions apply to this individual:

- DIETARY:**  Does not eat red meat       Does not eat dairy       Does not eat seafood       Does not eat peanut butter products  
 Does not eat pork       Does not eat eggs       Does not eat poultry       Other dietary restrictions? (explain below)

Please explain any other dietary restrictions.

\_\_\_\_\_  
\_\_\_\_\_

**ACTIVITIES:** Please explain any restrictions or limitations to activities, if any. The participant must acknowledge these restrictions with a signature below.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

<b>PARTICIPANT SIGNATURE REQUIRED</b>	I understand and agree to abide by the above dietary and/or activity restrictions placed on me.
<b>SIGNATURE OF PARTICIPANT:</b> _____	
Print your name: _____	Date: _____
<b>PAGE 2</b>	

**GENERAL QUESTIONS:** Has or does the participant:

- |  | YES                      | NO                       |  | YES                      | NO                       |
|--|--------------------------|--------------------------|--|--------------------------|--------------------------|
| 1. Had any recent injury, illness or infectious disease?.. | <input type="checkbox"/> | <input type="checkbox"/> | 16. Ever had back problems?.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have a chronic or recurring illness/condition?.....     | <input type="checkbox"/> | <input type="checkbox"/> | 17. Ever had problems with joints (eg. knees, ankles)?.....                      | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Ever been hospitalized?.....                            | <input type="checkbox"/> | <input type="checkbox"/> | 18. Have an orthodontic appliance being brought to camp?.....                    | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Ever had surgery?.....                                  | <input type="checkbox"/> | <input type="checkbox"/> | 19. Have any skin problems (acne, itching, rash)?.....                           | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have frequent headaches?.....                           | <input type="checkbox"/> | <input type="checkbox"/> | 20. Have diabetes?.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Ever had a head injury?.....                            | <input type="checkbox"/> | <input type="checkbox"/> | 21. Have asthma?.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Ever been knocked unconscious?.....                     | <input type="checkbox"/> | <input type="checkbox"/> | 22. Had mononucleosis in the past 12 months?.....                                | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Wear glasses, contacts, or protective eye wear? *.....  | <input type="checkbox"/> | <input type="checkbox"/> | 23. Had problems with diarrhea and/or constipation?.....                         | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Ever had ear infections?.....                           | <input type="checkbox"/> | <input type="checkbox"/> | 24. Have problems with sleepwalking?.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Ever passed-out during or after exercise?.....         | <input type="checkbox"/> | <input type="checkbox"/> | 25. If female, have an abnormal menstrual history?.....                          | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Ever been dizzy during or after exercise?.....         | <input type="checkbox"/> | <input type="checkbox"/> | 26. Have a history of bed-wetting?.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Ever had chest pain during or after exercise?.....     | <input type="checkbox"/> | <input type="checkbox"/> | 27. History of motion sickness?.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Ever had seizures?.....                                | <input type="checkbox"/> | <input type="checkbox"/> | 28. If yes, do you object to use of dramamine?.....                              | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Ever had high blood pressure?.....                     | <input type="checkbox"/> | <input type="checkbox"/> | 29. Have an eating disorder?.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Ever been diagnosed with a heart murmur?.....          | <input type="checkbox"/> | <input type="checkbox"/> | 30. Ever had emotional difficulties for which professional help was sought?..... | <input type="checkbox"/> | <input type="checkbox"/> |

\*PLEASE ATTACH A COPY OF THE PRESCRIPTION

Please explain any "yes" answers given above, noting the number of the question.

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**IMMUNIZATION INFORMATION:**

Which of the following have you had?

- Measles
- German Measles
- Mumps
- Chicken Pox
- Hepatitis A
- Hepatitis B
- Hepatitis C
- TB Mantoux test:  
Date of last test: \_\_\_\_\_  
Result:  Positive,  Negative

**INDICATE ALL DATES OF IMMUNIZATIONS FOR:**

<u>VACCINE</u>	<u>Month/Year</u>	<u>Month/Year</u>	<u>Month/Year</u>	<u>Month/Year</u>	<u>Month/Year</u>
DPT.....	_____	_____	_____	_____	_____
TD (tetanus/diphtheria).....	_____	_____	_____	_____	_____
Tetanus.....	_____	_____	_____	_____	_____
Polio.....	_____	_____	_____	_____	_____
MMR.....	_____	_____	_____	_____	_____
or Measles.....	_____	_____	_____	_____	_____
or Mumps.....	_____	_____	_____	_____	_____
or Rubella.....	_____	_____	_____	_____	_____
Haemophilus Influenza B.....	_____	_____	_____	_____	_____
Hepatitis B Vaccine.....	_____	_____	_____	_____	_____
Varicella (chicken pox).....	_____	_____	_____	_____	_____
MCV4 or MPSV4 (meningitis)..	_____	_____	_____	_____	_____

**PHYSICIAN CONTACT INFORMATION:**

Name of participant's physician: \_\_\_\_\_ Office phone #: \_\_\_\_\_

Office address: \_\_\_\_\_

Name of participant's dentist: \_\_\_\_\_ Office phone #: \_\_\_\_\_

Office address: \_\_\_\_\_

Name of participant's orthodontist: \_\_\_\_\_ Office phone #: \_\_\_\_\_

Office address: \_\_\_\_\_

**SIGNATURE REQUIRED**

This Health History is correct and complete. The participant herein described has permission to engage in all camp activities except as noted. Furthermore, I agree to notify the camp if the participant named above is exposed to any communicable disease within three weeks prior to camp attendance.

SIGNATURE OF PARENT, GUARDIAN, OR ADULT STAFF: \_\_\_\_\_ Date: \_\_\_\_\_

**SIGNATURE REQUIRED**

I agree to pay all medical charges relating to the participant. It is my understanding that local medical providers may require my credit card information (in addition to a copy of my insurance card) prior to treatment to be used for unpaid balances. I hereby authorize the physician, hospital, and/or any other medical provider, who has rendered outside medical treatment/care, to use my credit card for payment of medical charges incurred by the participant. I do not authorize the use of my credit card for any other purpose, unless otherwise indicated.

CREDIT CARD:  VISA,  MASTERCARD.

Name on card (print): \_\_\_\_\_ Account#: \_\_\_\_\_ Expires: \_\_\_\_\_

SIGNATURE OF CARD HOLDER: \_\_\_\_\_ Witness: \_\_\_\_\_

**RECOMMENDATIONS BY LICENSED MEDICAL PERSONNEL:**

I have examined this individual on (date of last examination): \_\_\_\_\_

BP \_\_\_\_\_, Weight \_\_\_\_\_, Height \_\_\_\_\_

In my opinion, the participant  is or  is not able to participate in an active camp program.

The applicant is under the care of a physician for the following conditions: \_\_\_\_\_

\_\_\_\_\_

Current treatment at time of this report includes: \_\_\_\_\_

\_\_\_\_\_

Treatment to be continued at camp - see page 2: \_\_\_\_\_

\_\_\_\_\_

Medications to be administered at camp including name, dosage, frequency – see page 2: \_\_\_\_\_

\_\_\_\_\_

Dietary restrictions or medically prescribed meal plan – see page 2: \_\_\_\_\_

Known allergies – see page 2: \_\_\_\_\_

\_\_\_\_\_

Description of any limitation or restriction on camp activities – page 2: \_\_\_\_\_

\_\_\_\_\_

Please provide any additional information about the participant's behavior, and physical, emotional and/or mental health: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**PHYSICIAN'S SIGNATURE REQUIRED**

**SIGNATURE OF LICENSED MEDICAL PERSONNEL:** \_\_\_\_\_

Print name: \_\_\_\_\_ Title: \_\_\_\_\_

Office address: \_\_\_\_\_

Telephone #: \_\_\_\_\_ Fax #: \_\_\_\_\_ Date: \_\_\_\_\_

**FOR CAMP USE ONLY - SCREENING RECORD**

Dates & times screened: \_\_\_\_\_

Medications received: \_\_\_\_\_

\_\_\_\_\_

Updates/additions to Health History noted?  Yes,  No,  None required.

Current health needs identified: \_\_\_\_\_

Observational notes: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Screened by: \_\_\_\_\_